STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN LIFE VILLAGES	9802 COLDWATER ROAD FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00107444 and IN00107486. Complaint IN00107444 - Substantiated. Federal/state deficiencies related to the allegations are cited at F502, F505, F514. Complaint IN00107486 - Unsubstantiated due to lack of evidence. Survey dates: April 30, and May 1, 2, 3, 2012 Facility number: 000283 Provider number: 155586 AIM number: 100275020 Survey team: Ann Armey, RN-TC Virginia Terveer, RN Census bed type: SNF/NF: 128 Residential: 45 Total: 173 Census payor type: Medicare: 14 Medicaid: 100 Other: 59 Total: 173	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/10/12 by Suzanne Williams, RN			

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F0502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on observation, interviews and record review, the facility failed to ensure a laboratory test was obtained within the time frame ordered. This deficiency affected 1 of 3 residents, whose laboratory tests were reviewed, in a sample of 8. (Resident #D) Findings include: On 4/30/12 at 10:45 a.m., during the orientation tour, RN #10 indicated Resident #D had been treated with Flagyl for C-difficille (Clostridium Difficille) and remained in contact isolation. Isolation supplies were observed hanging on a door mounted rack. The clinical record of Resident #D was reviewed on 5/1/12 at 3:40 p.m. and indicated the resident was admitted to the facility on 4/9/12 with diagnoses which included, but were not limited to, duodenal ulcers and PEG (Percutaneous Endoscopic Gastrostomy) tube placement. On 4/14/12, a laboratory report indicated the resident tested positive for	F0502	**1. What measures were taken for residents directly affected?** Resident #D received appropriate antibiotic therapy based on culture results of 05-02-2012. **2. What measures were put in place to identify other residents at risk?** All residents are at risk from this deficient practice. No similar instances are noted to have occurred since the survey dates. **3. What systemic change was put in place to ensure the deficient practice does not recur?** ·Policy on Physician Notification was reviewed and revised as deemed appropriate. ·The method for tracking lab orders was revised on 5/7/2012 to improve the timeliness in reporting and follow up. ·Facility process regarding delivery of lab results reviewed and modified. Lab results delivered directly to nursing units instead of being placed in Nurse Practitioner's mailbox for next visit review. ·Nursing Managers/Shift Supervisors/Nursing Office	06/02/2012

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	C-difficille. On 4/14/12, physician orders indicated the resident was to receive Flagyl 500 mg three times daily for ten days and the stool was to be rechecked 48 hours after the antibiotic was completed. The April 2012 MAR (Medication Administration Record) indicated he received the last dose of Flagyl on 2/24/12 at 4:00 p.m. The ADL (Activities of Daily Living) Flowsheet indicated the resident had 2 bowel movements, on the evening shift on 2/26/12 and did not have another bowel movement until 4/30/12. There was no documentation the repeat stool specimen was obtained 48 hours after the antibiotic had been completed or that the physician had been consulted about the delay in obtaining the stool specimen. On 5/1/12 at 7:32 a.m., nursing notes indicated a stool specimen had been obtained at 4:00 a.m. (7 days after the completion of the antibiotic) On 5/1/12 at 8:10 a.m., nursing notes indicated a stool specimen was sent to the laboratory.		Coordinator were in-serviced on the updated process regarding lab notifications which include the delivery of labs received directly to each of the nursing units instead of being placed in the Nurse Practitioner's mailbox for review. ·Nursing staff that perform physician notification have been in-serviced on the revised policy, specifically related to notifying the physician in the event that obtaining a culture specimen is delayed as well as abnormal lab results received. **4. How will the corrective action be monitored?** The Director of Nursing or designee will audit lab results requiring followup on a daily basis for 8 weeks and on a weekly basis for 12 weeks. A monthly report of findings will be submitted to the Quality Assurance Committee, which meets monthly, for the duration of the audits prescribed above. Should the committee feel that systemic compliance is not being achieved then audits will continue, with possible additional corrective action, until compliance has been achieved.	

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	On 5/1/12 at 3:00 p.m., LPN #11, indicated Resident #D was up all night with diarrhea and a stool specimen had been sent to the hospital. A laboratory report, dated 5/2/12, indicated the resident's stool tested positive for C-difficille. On 5/3/12 at 9:00 a.m., the DON (Director of Nursing) indicated they missed getting a stool specimen on 4/26/12, and the resident did not have another bowel movement until 4/30/12. This Federal tag relates to Complaint IN00107444. 3.1-49(a)			

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F0505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on observation, interviews and record reviews, the facility failed to promptly notify the physician regarding the results of a culture and sensitivity report. This deficiency affected 1 of 3 residents, whose laboratory reports were reviewed, in a sample of 8. (Resident #B) Findings include: On 4/30/12 at 11:00 a.m., during the orientation tour, RN #10 indicated Resident #B was currently in the hospital. Isolation supplies were observed hanging on a rack on Resident B's room door. RN #10 indicated Resident #B was admitted to the facility with VRE (Vancomycin Resistant Enterococcus). The clinical record of Resident #B was reviewed on 4/30/12 at 2:30 p.m. and indicated the resident was admitted to the facility on 3/29/12, with diagnoses which included, but were not limited to, anoxic brain syndrome and a pseudoaneurysm repair with incisional wound. Resident #B was transferred to the hospital on 4/19/12. Nursing notes, dated 3/29/12 at 11:45	F0505	**1. What measures were taken for residents directly affected?** No residents were directly affected by this practice. Resident #B was admitted to the hospital on 04-19-2012 and has subsequently been discharged from the facility. **2. What measures were put in place to identify other residents at risk?** All residents are at risk from this deficient practice. No similar instances are noted to have occurred since the survey dates. **3. What systemic change was put in place to ensure the deficient practice does not recur?** ·Policy on Physician Notification was reviewed and revised as deemed appropriate. ·Nursing staff that perform physician notification have been in-serviced on the revised policy, specifically related to physician notification of abnormal lab results. ·Facility process regarding delivery of lab results reviewed and modified. Lab results delivered directly to nursing units instead of being placed in Nurse Practitioner's mailbox for next visit review.	06/02/2012

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	a.m., indicated "...L (left) groin has a wound noted that has a hx (history) of VRE. There is no documentation that VRE is cleared; therefore, contact precautions initiated and observed." On 4/2/12, and order was written for "C&S (culture and sensitivity) wound." On 4/5/12, a preliminary culture report for the wound indicated there was heavy growth and a sensitivity report would follow. On 4/6/12, the sensitivity report for the wound was reported and faxed to the facility. The final culture sensitivity report indicated the Resident #B cultured positive for Kluvera Ascorbata, Escherichia Coli, and Enterococcus Faecium VRE (Vancomycin Resistant Enterococcus). There was no documentation the physician was notified regarding the final culture report until 4/9/12 (3 days after it had been received by the facility). A Nurse Practitioner note, dated 4/9/12, indicated "wound C&S (Culture and Sensitivity) returned." On 4/9/12, two intravenous antibiotics were ordered to treat the wound infection.		·Nursing Managers/Shift Supervisors/Nursing Office Coordinator were in-serviced on the updated process regarding lab notifications which include the delivery of labs received directly to each of the nursing units instead of being placed in the Nurse Practitioner's mailbox for review. **4. How will the corrective action be monitored?** The Director of Nursing or designee will audit lab results requiring followup on a daily basis for 8 weeks and on a weekly basis for 12 weeks. A monthly report of findings will be submitted to the Quality Assurance Committee, which meets monthly, for the duration of the audits prescribed above. Should the committee feel that systemic compliance is not being achieved then audits will continue, with possible additional corrective action, until compliance has been achieved.	

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	The order indicated Resident #B was to receive Zosyn 3.37 every six hours for ten days and Linesolid 600 mg every 12 hours for ten days. On 5/3/12 at 9:00 a.m., the DON (Director of Nursing) indicated the final wound culture and sensitivity report was placed in the Nurse Practitioner's box so it could be reviewed during her next visit. The DON indicated the report should have been called to the nurse practitioner when it was received on 4/6/12. The Policy and Procedure for Physician Notification, revised 3/2012, provided by the DON, was reviewed on 5/3/12 at 9:15 a.m., indicated the physician should be notified immediately for "...Any panic lab value or labs with a specific physicians' order...." This Federal tag relates to Complaint IN00107444. 3.1-49(f)(2)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to document the removal of an intravenous mid line catheter, the administration of intravenous medications and wound treatments. This deficiency affected 1 of 2 residents reviewed, who received intravenous medications and 1 of 3 residents, who received wound treatments, in a sample of 8. (Resident #B) Findings include: 1. The clinical record of Resident #B was reviewed on 4/30/12 at 2:30 p.m. and indicated the resident was admitted to the facility on 3/29/12, with diagnoses, which included but were not limited to, anoxic brain syndrome. Resident #B was transferred to the hospital on 4/19/12.	F0514	**1. What measures were taken for residents directly affected?** No residents were directly affected by this practice. Resident #B was admitted to the hospital on 04-19-2012 and has subsequently been discharged from the facility. **2. What measures were put in place to identify other residents at risk?** All residents are at risk from this deficient practice. No similar instances are noted to have occurred since the survey dates. **3. What systemic change was put in place to ensure the deficient practice does not recur?** ·Policy on Physician Orders was reviewed with no revisions indicated. ·Policy on Peripheral Catheter Removal was reviewed with no revisions indicated. ·Nursing staff were in-serviced on appropriate documentation	06/02/2012

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	Nursing notes, dated 3/29/12 at 11:45 a.m., indicated "...L (left) groin has a wound noted that has a hx (history) of VRE. There is no documentation that VRE is cleared; therefore, contact precautions initiated and observed." On 4/6/12, the sensitivity report for the wound was reported and faxed to the facility. The final culture sensitivity report indicated the Resident #B cultured positive for Kluvera Ascorbata, Escherichia Coli, and Enterococcus Faecium VRE (Vancomycin Resistant Enterococcus). On 4/9/12, two intravenous antibiotics were ordered to treat the wound infection. On 4/10/12 at 3:34 a.m. nursing notes indicated a midline intravenous catheter was place in the right inner arm. On 4/13/12 at 1:50 p.m., clinical infusion documentation indicated a midline intravenous catheter was placed in the left arm. There was no documentation why the intravenous catheter in the right arm had been removed. On 5/3/12 at 9:00 a.m., the DON		specifically related to the above noted policies ·Nurse Managers were in-serviced on Exception Report review, an auditing process generated by the facility's EMR system which allows management staff to review documentation for EMAR and ETAR. **4. How will the corrective action be monitored?** The Director of Nursing or designee will audit all documentation on a daily basis through the use of Exception Reports for 8 weeks and on a weekly basis for 12 weeks. A monthly report of findings will be submitted to the Quality Assurance Committee, which meets monthly, for the duration of the audits prescribed above. Should the committee feel that systemic compliance is not being achieved then audits will continue, with possible additional corrective action, until compliance has been achieved.	

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	(Director of Nursing) indicated she determined the intravenous catheter had accidentally been pulled out during morning care on 4/13/12 . The DON indicated the incident had not been documented. The policy for the Peripheral Catheter Removal, revised 8/15/08, provided by the DON, and reviewed on 5/3/12 at 9:15 a.m., indicated; "...15. Documentation in the medical record includes, but is not limited to: 15.1 Date and time 15.2 Reason for removal 15.3 Length and condition of catheter 15.4 Site assessment...." The April 2012 MAR (Medication Administration Record) indicated Resident #B was to receive the antibiotics Zosyn 3.375 grams per intravenous infusion every six hours and Zyvox 600 mgs per intravenous infusion every twelve hours. The Zosyn was not initialed as given on 4/17/12 at 12:00 a.m. and 6:00 a.m. The Zyvox was not initialed as given on 4/16/12 at 12:00 a.m. and on 4/17/12 12:00 a.m. On 5/3/12 at 9:00 a.m., the DON indicated she had not found an explanation regarding why the antibiotics			

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	had not been initialed as given on the MAR but found notes on the 24 hour worksheets indicating the intravenous medications had been given. She indicated they were looking into the factors related to the electronic medication documentation/report system. The March and April 2012 TARs (Treatment Administration Records) indicated Resident #B was to receive a wet to dry dressings (using a gentamycin/dakin solution), to a wound on the left groin, twice daily, starting on 3/29/12. The treatment was not initialed as being done on 12 occasions between 3/30/12 through 4/16/12, as follows: 3/30/12, on the day shift, 3/31/12, on the evening shift, 4/3/12, on the day shift, 4/6/12, on the evening shift, 4/7/12, on the evening shift, 4/12/12, on the day shift, 4/12/12, on the evening shift, 4/13/12, on the day shift, 4/13/12, on the evening shift, 4/14/12, on the evening shift, 4/15/12, on the evening shift., and 4/16/12, on the day shift. On 5/3/12 at 9:00 a.m., the DON indicated she had talked to the nursing staff on Resident #B's unit. The DON			

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	indicated the staff felt the treatments had been done because the family requested the dressing changes be dated with a time. The DON indicated she had found documentation in the nursing notes indicating the treatment had been done on three of the twelve days (4/10/12, 4/15/12, and 4/16/12). Physician orders, dated 4/9/12, indicated RX Compound was to be applied on Resident #B's right buttocks every shift until the redness was healed. On the April 2012, TAR, the RX Compound treatment was not initialed as done on five occasions, between 4/10/12 and 4/18/12, as follows: the evening shift on 4/12, 13, 14/12 and the night shift on 4/16/12. On 5/3/12 at 9:00 a.m., the DON indicated she was not able to find any documentation indicating the treatments were done. The policy for Physician orders, dated 2/1/12, provided by the DON, reviewed on 5/3/12 at 9:15 a.m., indicated "...orders will be double checked by the night shift licensed staff to insure they are on the EMAR, orders are correctly written, etc and all corrections handled as able or reported to the oncoming shift for process			

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	completion..." This Federal tag relates to Complaint IN00107444. 3.1-50(a)(1)			